freshwater
FAMILY MEDICAL CENTRE

# NEW PATIENT REGISTRATION FORM

In order to provide you with the highest quality of care, we require the following information from you. This form complies with the RACGP *Standards for general practices (5th edition)*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you haveconcerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly when required.

**Please print letters.**
**Use black or blue pen.**
**Place 'X' in all applicable boxes.**

## SECTION A: **Personal details**

**Title** | **Surname** | **Given name**

**Date of birth** (if applicable) / / | **Gender** M ☐ F ☐

**Medicare card number** | **Medicare reference number** | **Medicare expiry date** / /

**Pension, Health Care Card, or Veterans Affairs number** (if applicable) | **Policy number** | **Expiry date** / /

Occupation

Home address | Postcode

Postal address | Postcode

Telephone number | Work number | Mobile number

Email

**Next of Kin**

Name | Relationship to you

Telephone number | Work number | Mobile number

**Who can we contact in an emergency?**

Name | Relationship to you

Telephone number | Work number | Mobile number

## SECTION B: **Cultural background**

**Knowing your cultural background can help us provide healthcare that meets your individual needs.**

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐ Yes, both Aboriginal and Torres Straig Islander ☐

Your country of birth

## SECTION C: **Allergies and medicines**

| **List allergies and intolerances to medications** | **st regular medications and doses** |
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## SECTION D: **Consent**

Our practice may use a reminder system to help you maintain your health. The practice may send reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews.

**I consent to being contacted with reminders to help me maintain my health** Yes ☐ No ☐

Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move.

**I consent to being contacted with reminders to help me maintain my health** Yes ☐ No ☐

**Signature of patient or guardian**

**Date**

/ /

## SECTION E: **Transfer of health information**

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

**Please advise us if your contact information for Medicare details change.**